

Individual Information

Name		Interim Plan of Care Effective Date	IPC Period (From – To)
1. Date of Birth (mm/dd/yyyy)	2. Medicaid No.		3. Social Security No.
4. Primary Caregiver(s)			5. Relationship to Individual
6. Primary Caregiver(s)' Area Code and Telephone No.		7. New Resource Utilization Group (RUG)	8. Previous RUG

Part I — Medical Assessment (to be completed by DADS nurse)

9. The following medical information was obtained from <input type="checkbox"/> Family <input type="checkbox"/> Physician <input type="checkbox"/> Other (specify): _____ Person Interviewed: _____			
10. Indicate any additional diagnoses or change in diagnosis(es) since last assessment:			
11. Give dates and reasons for any hospitalization since previous assessment:			
12. Describe any changes in the individual's health information (including nutritional status, developmental disabilities, mobility, functional limitations, treatment, medical equipment/assistive devices in use or needed, and prognosis) since previous assessment:			
Signature – MDCP Nurse		Date	Region
			Area Code/Telephone No.

Part II — Social Assessment (to be completed by the case manager)

13. Reason for Interim Plan of Care (explain need that will be met – be specific):			
14. Describe any changes in the individual's social situation (including functioning, status of primary caregiver's ability to provide care, family relationships/dynamics, financial/employment situations, social resources, inclusion activities, and permanency planning):			
15. Describe any changes (additions/reductions) in other services (for example, personal care services, comprehensive care program, insurance covered care, education services, childcare):			
16. Describe the primary caregiver(s)' need for hours under Interim Plan of Care or attach scheduling grid (Form 2410, Medical-Social Assessment and Individual Plan of Care, Part IIB):			

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Part IV — Interim Plan of Care/Budget Worksheet

20. SSI Eligible: Yes No Date Verified:

21a. RUG:

21b. New IPC cost limit for the **new** RUG: \$

21c. Enter prorated daily cost limit (amount in 21b divided by the number of days in the IPC period): \$

21d. Enter number of days from the Interim Plan of Care effective date through the end of the IPC period:

21e. Enter prorated IPC cost limit for the remainder of IPC period (amount in 21c multiplied by number in 21d): \$

21f. **Estimated Cost Limit for this IPC Period:** Add previous authorized expenditures + amount from 21e. \$

22. Respite (R)/Flexible Family Support Services (F): Child Care Independent Living Post Secondary Ed

A. Authorized Before Interim Period (may use authorized or expended and encumbered)				e. Provider Type	f. Hrs/Wk	X	g. # of Wks	=	h. Total # of Hrs	@	i. Rate per Hr	=	j. Cost
a. Service Code	b. R, F, FR or FF	c. From (Start of IPC Period)	d. To (Day Before Interim Begins)										
						X		=		@		=	
						X		=		@		=	
						X		=		@		=	
						X		=		@		=	
						X		=		@		=	
						X		=		@		=	
						X		=		@		=	
						X		=		@		=	
22 k. Total 1A:													

B. Authorized for Interim Period				p. Provider Type	q. Hrs/Wk	X	r. # of Wks	=	s. Total # of Hrs	@	t. Rate per Hr	=	u. Cost
l. Service Code	m. R, F, FR or FF	n. From (Day Interim Begins)	o. To (End of IPC Year)										
						X		=		@		=	
						X		=		@		=	
						X		=		@		=	
						X		=		@		=	
						X		=		@		=	
						X		=		@		=	
						X		=		@		=	
						X		=		@		=	
22 v. Total 1B:													

23. Minor Home Modifications (Service Code 16):

A. Authorized Before Interim Period (include only items paid or items delivered and not paid)			
a. Type of Modification	b. Estimated (or Actual) Cost	c. Spec. Fee	d. Maximum Authorization = b + c
23e. Total 2A:			\$

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Part IV — Interim Plan of Care/Budget Worksheet (continued)

23. Minor Home Modifications (continued)

B. Authorized for **Interim Period** (include any new items already planned, but not delivered)

f. Type of Modification	g. Estimated (or Actual) Cost	h. Spec Fee	i. Maximum Authorization = g + h
23j. Total 2B:			\$

23k. Add all items in 23b + 23g = \$; \$7500 lifetime service limit

24. Authorized Maintenance/Repair of Home Modifications

24a. Enter amount authorized **before** Interim Period: Total 3A: \$

24b. Enter amount authorized for **Interim Period**: Total 3B: \$

24c. Add Total 3A + Total 3B = \$; \$300 maximum per IPC period

25. Adaptive Aids (Service Code 15):

A. Authorized **Before** Interim Period (include only items paid or items delivered and not paid)

a. Type of Adaptive Aid	b. Estimated (or Actual) Cost
25c. Total 4A:	
\$	

B. Authorized for **Interim Period** (include any new items or items previously planned, but not delivered)

d. Type of Adaptive Aid	e. Estimated (or Actual) Cost
25f. Total 4B:	
\$	

25g. Add Total 4A + Total 4B = \$; \$4000 maximum per IPC period

26. Financial Management Services (Service Code 63V):

A. Authorized **Before** Interim Period

a. Total Number of Units Authorized	b. Rate per Unit	c. Maximum Authorization
26d. Total 5A:		\$

B. Authorized for **Interim Period** (include any new units or units previously authorized, but not delivered)

e. Total Number of Units Authorized	f. Rate per Unit	g. Maximum Authorization
26h. Total 5B:		\$

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Part IV — Interim Plan of Care/Budget Worksheet (continued)

27. Transition Assistance Services (Service Code 53 and 53A):			
A. Authorized Before Interim Period			
a. Total Amount Authorized	b. TAS fee	c. Maximum Authorization (Total 6A)	
		\$	
B. Authorized for Interim Period			
d. Total Amount Authorized	e. TAS fee	f. Maximum Authorization (Total 6B)	
		\$	
28. Interim Plan of Care Estimated Cost of Waiver Services: \$			
Interim Plan of Care Estimated Cost of Waiver Services must not exceed maximum total for IPC period (see line 21f). If the amount on line 28 exceeds the amount on line 21f, revise the Interim Plan of Care.			
29. Individual's Address	30. City	31. ZIP Code	32. Area Code/Telephone No.
33. Primary Caregiver(s)		34. Relationship to Individual	

Part V — Interim Plan of Care – Signature/Approval

35. Individual's/Caregiver's Approval: signature is required (refer to current annual IPC). <input type="checkbox"/> Yes <input type="checkbox"/> No	
If No, complete verbal consent section below and send copy of completed Interim Plan of Care to the individual/caregiver. If Yes, submit the Interim Plan of Care to the individual/caregiver for approval. I participated in the development of this revised plan of care with the case manager. I have reviewed my rights and responsibilities and understand that I continue to have the right to make changes to the plan of care before the end of the plan year, and that I may do so by contacting my case manager. I understand that my signature is required for services to be authorized and that my signature does not affect my right to a fair hearing if I disagree with this revised plan.	
Individual/Caregiver Name (Type or Print)	
_____ Signature – Individual/Caregiver	_____ Date
36. Case Manager: This Interim Plan of Care was developed in collaboration with the individual and/or primary caregiver(s). I have reviewed the rights and responsibilities with the individual/caregiver, and I have informed them that they have the right to make additional changes to the plan of care before the end of the plan year and may do so by contacting me.	
Case Manager Name (Type or Print)	
_____ Signature – Case Manager	_____ Date
Verbal Consent (Complete this section only if parent has indicated that they authorize the case manager to make changes in the plan of care with verbal permission of the primary caregiver.): I spoke with _____ (individual/caregiver) on _____ (date) and revised the individual's plan of care in collaboration with the caregiver, reviewing their rights and responsibilities. A copy of the revised plan was mailed to the individual/caregiver on _____ (date).	
Case Manager Name (Type or Print)	
_____ Signature – Individual/Caregiver	_____ Date
I confirmed with _____ (individual/caregiver) on _____ (date) that they authorized the changes resulting in an Interim Plan of Care and that they understood their rights and responsibilities.	
Witness Name (Type or Print)	
_____ Signature – Witness	_____ Date